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<b>State:</b>	Arkansas	<b>Filing Company:</b>	Reliable Life Insurance Company
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other		
<b>Product Name:</b>	Life Insurance		
<b>Project Name/Number:</b>	Life Insurance Application/5289-RL4		

## Filing at a Glance

Company:	Reliable Life Insurance Company
Product Name:	Life Insurance
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	08/02/2012
SERFF Tr Num:	UUIN-128608505
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	5289-RL4
Implementation	11/01/2012
Date Requested:	
Author(s):	Carol Davenport
Reviewer(s):	Linda Bird (primary)
Disposition Date:	08/13/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Life Insurance  
**Project Name/Number:** Life Insurance Application/5289-RL4

**Filing Company:** Reliable Life Insurance Company

## General Information

Project Name: Life Insurance Application

Project Number: 5289-RL4

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Carol Davenport

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: State of domicile is Missouri.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 08/13/2012

State Status Changed: 08/13/2012

Created By: Carol Davenport

Corresponding Filing Tracking Number:

Filing Description:

On behalf of Reliable Life Insurance Company, form 5289-RL4, Application for Insurance is submitted. This form has been revised to change references to the "Medical Information Bureau", to read "MIB. Inc.".

The form has also been reformatted to:

- Provide more space for the customer to provide answers to the questions presented.
- Remove the company logo and the reference to "A Unitrin Company"

There are no other changes to the text of the form.

## Company and Contact

### Filing Contact Information

Carol Davenport, Director of Regulatory Compliance      csdavenport@kemper.com  
12115 Lackland Road      314-819-4655 [Phone]  
St. Louis, MO 63146

### Filing Company Information

Reliable Life Insurance Company	CoCode: 68357	State of Domicile: Missouri
12115 Lackland Rd.	Group Code: 215	Company Type: Life &
St. Louis, MO 63146	Group Name: Unitrin, Inc.	Accident
(314) 819-4627 ext. [Phone]	FEIN Number: 43-0476110	State ID Number:

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	1 form @ \$50.00/each
Per Company:	No

Company	Amount	Date Processed	Transaction #
Reliable Life Insurance Company	\$50.00	08/02/2012	61385794

<b>SERFF Tracking #:</b>	UUIN-128608505	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	5289-RL4
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Reliable Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other				
<b>Product Name:</b>	Life Insurance				
<b>Project Name/Number:</b>	Life Insurance Application/5289-RL4				

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/13/2012	08/13/2012

<b>State:</b>	Arkansas	<b>Filing Company:</b>	Reliable Life Insurance Company
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other		
<b>Product Name:</b>	Life Insurance		
<b>Project Name/Number:</b>	Life Insurance Application/5289-RL4		

## Disposition

Disposition Date: 08/13/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Application for Life Insurance		Yes

<b>State:</b>	Arkansas	<b>Filing Company:</b>	Reliable Life Insurance Company
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other		
<b>Product Name:</b>	Life Insurance		
<b>Project Name/Number:</b>	Life Insurance Application/5289-RL4		

## Form Schedule

Lead Form Number:							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		5289-RL4	AEF	Application for Life Insurance	Revised: Replaced Form #: 5289-RL2 Previous Filing #: UUIN-126765853	50.500	5289-RL4.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

H.O. Use Only

District Agency

Family Group  
Number:Family Group  
Name:

Application for Insurance to

**The Reliable Life Insurance Company**HOME OFFICE: St. Louis, Missouri 63146 (800) 630-8645  
**PLEASE PRINT ALL INFORMATION IN BLACK INK**

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**If adding benefits to existing policy,  
indicate policy #**

1. Proposed Insured Owner (First, Middle Initial, Last)						Age	Birth Date				Sex	Height ft in	Weight		
Residence Number and Street						Town or City		State		Zip Code		Driver's License Number:			
Social Security Number:						Telephone Number		Birth State	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law Spouse		State of Issue:				
<input type="checkbox"/> Single <input type="checkbox"/> Divorced															
Occupation/Source of Income of Proposed Insured:															
2. Name of Other Persons Proposed for Insurance: (Spouse or Child)				Social Security Number				Relationship	Sex	Age	Birth Date		Birth State	Height (Ft) (In)	Weight (Lbs.)
2a. Are all children proposed for insurance living in the home of the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain on supplement.								3. Has any person proposed for insurance smoked cigarettes or used tobacco products within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No							
4. Policy Plan		5. Face Amount		6. Total Premium		7. Payable: <input type="checkbox"/> Monthly (MDO) <input type="checkbox"/> Bank Transfer <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual									
8. Additional Benefits:		Amount		<input type="checkbox"/> Waiver of Premium Rider <input type="checkbox"/> (10 / 20 / 65) Term Rider (circle year selection) <input type="checkbox"/> (15/30) Mort. Term Rider <input type="checkbox"/> ADB on Term Rider		Amount		<b>MDO: \$25,000 or less on base plan</b> <b>PNO: \$30,000 or more on base plan</b>							
<input type="checkbox"/> Accidental Death Rider <input type="checkbox"/> Child Rider <input type="checkbox"/> Spouse Rider <input type="checkbox"/> Spouse ADB Rider															
9. Proposed Insured is Owner <input type="checkbox"/> Yes <input type="checkbox"/> No MUST BE COMPLETED if "No"								Birth Date		Relationship		Social Security Number			
Primary															
Address															
9a. Contingent															
10. Primary Beneficiary				Name		Percent		Birth Date		Relationship		Social Security Number			
10a. Contingent Beneficiary				Name		Percent		Birth Date		Relationship		Social Security Number			

**AGREEMENT**

IT IS AGREED that all statements in this application are, to the best of my (our) knowledge and belief, complete and true. This application and any amendments to it, with the answers made to the medical examiner (should an exam be required) shall be the basis of any insurance issued. No agent can: a) accept any risks; b) modify policies; or c) waive any rights or requirements of The Reliable Life Insurance Company (Company). It is further agreed that unless otherwise stated in a Conditional Receipt bearing the date of this application, no liability exists until: a) a policy is delivered to and accepted by the owner; and b) the first premium is paid while the health and occupations of all proposed Insureds are as described in this application. The acceptance of any policy issued on this application shall be an acceptance and ratification of all corrections, additions or changes made by the Company. Any change in the amount of insurance, class, plan of insurance, benefits or the age at issue must be accepted, in writing, by the applicant. I authorize MIB, Inc. to provide any information it has on me and my minor children to the Company in connection with this application. I authorize the Company to make a brief report of my personal health information to MIB, Inc. I ACKNOWLEDGE receipt of the Disclosure Notice to Proposed Insured.

☐ I ELECT to be interviewed if an investigative consumer report is prepared in connection with this application.

Cash Received with Application \$

Dated and Signed at

Mo/Day/Yr

City

State

X

Witness or Agent Signature

Employee Number

X

Signature of Proposed Insured (who is the Owner unless otherwise designated above)

X

Signature of Applicant/Owner (if other than Proposed Insured)

Signature of 2nd Proposed Insured (or spouse, if insurance is applied for)

11. Replacement exists when a policy is lapsed, surrendered or "substantially borrowed against" in the 4 months before or 13 months after the application date of a new or increased policy on the same life. Is this policy intended to in whole or in part replace any life insurance?  
☐ Yes ☐ No If yes, please complete any applicable forms.
12. Does any person proposed for insurance have life insurance in force or applied for with this or any other company? ☐ Yes ☐ No If "yes", list information here, including any Accidental Death Benefit Coverage. Include all Reliable Life Insurance Company policy numbers.

INSURED	COMPANY	POLICY NO.	LIFE INS. AMOUNT	ISSUE OR APP. DATE

### MEDICAL QUESTIONS - COMPLETE FOR ALL PROPOSED INSURED

**Has (or is) any Person proposed for insurance: (All Primary Proposed Insureds and any spouse or Civil Union Partner applying for STR must initial each and every response to the following questions). Circle applicable condition(s), place initials wholly in box provided and give complete details in Question 25.**

	Yes	No
13. Consulted a physician or other medical practitioner or been hospitalized for any reason during the last 5 years?.....		
14. Ever been treated for or diagnosed with asthma, bronchitis, emphysema, pleurisy, or other disease or disorder of the lungs?.....		
15. Ever been treated for cancer, tumor, heart trouble, blood disorders, diabetes, high or low blood pressure or elevated cholesterol?.....		
16. Ever been treated for disease or disorder of stomach, intestines, rectum, liver or gall bladder, ulcer, rupture or gland disorder?.....		
17. Ever been treated for mental or nervous disorder, fainting spells, epilepsy or convulsions, paralysis or stroke?.....		
18. Ever been treated for disease or disorder of the kidney, bladder, prostate, trouble with the male or female sexual or reproductive organs, or for venereal disease?.....		
19. Ever been treated for disease or disorder of bone, joints, muscle, back or spine; rheumatism, arthritis, gout, loss of limb or deformity?.....		
20. Within the last 3 years had a drunk driving conviction, had any moving violations, auto accidents, or participated in any motor racing or aviation activities, skin diving, scuba diving, skydiving, or any other hazardous sport?.....		
21. Currently receiving Social Security Disability benefits, supplemental security income benefits due to disability, or health or medical benefit payments under Medicaid?.....		
22. a. Ever been treated by a doctor or in a hospital or other medical facility because of alcohol, drug or narcotic usage; or been diagnosed as suffering from alcohol or drug abuse?.....		
b. Ever used marijuana, barbiturates, amphetamines, hallucinatory drugs, heroin, cocaine, opiates or other narcotics, except as prescribed by a physician?.....		
23. Ever been declined, postponed or offered insurance at a higher rate from that applied for?.....		
24. Ever been treated or diagnosed by a physician or medical professional as having AIDS, ARC, or any immunological disorder (including testing positive for the HIV virus)? .....		

**WARNING: Any person who knowingly includes any false or misleading information on an application for an insurance policy, or who makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony and may be subject to fines and confinement in prison.**

25. Give complete details of "yes" answers to Question 13 -24 and information on all Medical Care Providers:

Provider's Full Name	Full Telephone No.	Complete Address	Indicate Question No. and include full details and date



Proposed Insured \_\_\_\_\_

**AGENT'S REPORT****1. COMPLETE WHEN INDIVIDUAL PROPOSED INSURED IS UNDER AGE 15:**

a. On the back of this report, list all children under the age of 15, and the amount of insurance on each.

b. How much insurance coverage does the father have? \_\_\_\_\_ Does the mother have? \_\_\_\_\_

**2. COMPLETE WHEN A CHILD RIDER IS REQUESTED:**a. Is each child named on the application a natural child, a stepchild or a legally adopted child of the Proposed Insured? ☐ Yes ☐ No  
Provide details of "No" answer.b. Are all children under the age of 18 included in this application? ☐ Yes ☐ No Provide details of "No" answer.**3. COMPLETE FOR ALL APPLICATIONS:**a. Did you see the Proposed Insured(s) when this application was completed? ☐ Yes ☐ No

b. How long have you known the Proposed Insured, or, if the Proposed Insured is a child under the age of 15, how long have you known the applicant? \_\_\_\_\_

c. Does the applicant have any existing life insurance policies? ☐ Yes ☐ Nod. Replacement exists when a policy is lapsed, surrendered or "substantially borrowed against" in the 4 months before or 13 months after the application date of a new or increased policy on the same life. Do you have reason to believe replacement is involved in this transaction? ☐ Yes ☐ Noe. Has a Medical Examination been ordered? ☐ Yes ☐ No Date ordered: \_\_\_\_\_ From: \_\_\_\_\_f. Has an Inspection Report been ordered? ☐ Yes ☐ Nog. If the amount of insurance applied for is \$100,000 or greater or the premium is \$1,000 or more, the identity and address of the insured/applicant was verified? ☐ Yes ☐ No Photo ID used was \_\_\_\_\_\_\_\_\_\_  
Signature of Writing Agent\_\_\_\_\_  
Employee Number\_\_\_\_\_  
Date**CONDITIONAL RECEIPT - DO NOT DETACH UNLESS FIRST PREMIUM IS PAID WITH APPLICATION****ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY  
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

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The Reliable Life Insurance Company has received a payment of \$ \_\_\_\_\_ for insurance applied for on the life of \_\_\_\_\_ with this application.

No insurance will be provided under this receipt unless all Company Requirements are first fulfilled exactly during the lifetime of the Proposed Insured. If all Company requirements are not met, or the Proposed Insured dies by suicide, the liability of the Company shall be limited to a refund to the Applicant of the payment made for this receipt. Company Requirements are defined by the Company's current rules and practices and include hospital and physician reports, medical examinations, tests and any other information requested by the Company. No agent may alter or waive any part of this receipt. This receipt provides no insurance for riders or additional benefits.

**IMPORTANT:** The payment is accepted by the Company subject to the conditions set forth on the back of this receipt. This receipt is not valid unless it is signed by a licensed agent of the Company and unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment.

\_\_\_\_\_  
DATE\_\_\_\_\_  
SIGNATURE OF AGENT\_\_\_\_\_  
EMPLOYEE NUMBER**DISCLOSURE NOTICE TO PROPOSED INSURED****Consumer Disclosure Notification**

As part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews made by a consumer reporting agency with you, your family, neighbors, friends and others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. In addition, physicians, hospitals, clinics and other medically-related facilities may be contacted, using your signed authorization to obtain details of your past medical treatment.

You have the right to be interviewed as a part of any investigative consumer report that may be prepared. If you desire to be interviewed, you should indicate this on the space provided in the Authorization. You also have the right of access, correction and amendment with respect to any personal information collected. Upon your request, you are entitled to receive a description of procedures which allow access to, and correction of personal information which may be obtained, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to Home Service Insurance Services, The Reliable Life Insurance Company, 12115 Lackland Rd., St. Louis, Missouri 63146.



## Question 1.a. listing of children under the age of 15

Name	Age	Amount of Insurance

## REFERRALS:

Name	Address	Phone No.

Perf

## LIFE APPLICATION - CONDITIONAL RECEIPT (CONTINUED)

**Conditions** - For insurance to be effective, the following conditions must be fulfilled:

- All Company Requirements have been completed and received by the Company within 60 days from the date of the application;
- The first premium has been paid in full;
- All questions in the application have been answered;
- All answers given in the application are true and complete, and
- The Proposed Insured is acceptable to the Company under its rules and practices, for the plan and amount applied for, without amendment, at the rate class applied for at the standard premium, as of the date all the Company Requirements are received by it.

**Start of Insurance** - If all the above requirements are met, this Receipt will provide insurance beginning the later of: (1) the date of the application; or (2) the date of receipt of all requirements.

**End of Insurance** - Once begun, any insurance this Receipt may provide ends at the earliest of: (1) 60 days after the date of the application; (2) when the Company sends a refund of the premium received in exchange for this Receipt; or (3) the date any policy issued goes into effect.

**Amount Limit** - The amount of insurance provided by this Receipt is the lesser of: a) the face amount of the insurance applied for in the application; or b) \$50,000.

Perf

## DISCLOSURE NOTICE TO PROPOSED INSURED

## MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. The Reliable Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB Inc. (formerly Medical Information Bureau), a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB Inc. will arrange disclosure of any information in your file. Please contact MIB Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB Inc.'s file, you may contact MIB Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Reliable Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB Inc. may be obtained on its website at [www.mib.com](http://www.mib.com).

<b>SERFF Tracking #:</b>	UUIN-128608505	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	5289-RL4
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Reliable Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other				
<b>Product Name:</b>	Life Insurance				
<b>Project Name/Number:</b>	Life Insurance Application/5289-RL4				

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
5289-RL4 Certification.pdf			

## CERTIFICATION

This is to certify that the attached:

5289-RL4

has achieved Flesch reading ease score of 50.5 and complies with the requirements of Ark. Stat. Ann. §66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

*Carol Davenport*

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Signature

Carol Davenport  
Director, Regulatory Compliance

*7-31-12*

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Date